DEPARTMENT OF HUMAN SERVICES
SENIORS & PEOPLE WITH DISABILITIES SERVICES
500 Summer Street NE E02
Salem, Oregon 97301-1073
Phone: (503) 945-5811

AUTHORIZED BY: _____
SPD Assistant Director/
Deputy Assistant Director/
Administrator

INFORMATION MEMORANDUM
SPD-IM-03-008
Date: January 16, 2003

TO:

Area Agency on Aging Directors	CHS SDA Managers
CHS/SPD Field Managers and Staff	CHS SDA Assistant Managers
CHS All Senior Program Managers	CHS Central Office Managers

SUBJECT: Senior Prescription Drug Assistance Program

INFORMATION:
The Senior Prescription Drug Assistance Program begins February 1, 2003. This program allows Oregonians, age 65 and older, who do not qualify for other medicaid programs to purchase prescription drugs from participating pharmacies at the State Medicaid rate .

To be eligible, members must:
- Be 65 years of age or older
- Have income that is under 185% of the federal poverty level ($1365.30)
- Have less than $2000 in liquid resources (member's primary residence and care do not count as resources)
- Not have been covered by any public, or private drug benefit program for the previous 6 months (this includes Medicaid but does not include discount programs)
- Pay annual fee of $50.00

The process is as follows:
1. Client calls 1-800-359-9517 or TTY 1-800-621-5260 to request an application, form DHS 7212 (copy attached). Workers can get the application by contacting Glenn Slowey, phone: (503) 378-2758 or fax: (503) 378-2828.
2. Client sends completed application to OHP Central Processing Branch
3. OHP Central Processing Branch approves, pends or denies the request.
4. OHP Central Processing Branch sends the appropriate notification.
5. When approved, the client is sent a bill for $50.00.
6. Upon receipt of the annual fee of $50.00, the client is sent a membership card the size of a credit card.
7. The client presents the card at the pharmacy and receives a discount on prescriptions.

(If eligible, mail order service is available through Wellpartner Pharmacy toll-free at 1-877-935-5797, Monday thru Friday, 8:00am to 5:00pm.)

CONTACT: Sandy Wood, OMAP **PHONE:** 503 945-6530
E-MAIL: sandy.a.wood@state.or.us **FAX:** 503 373-7689

For help filling out this application, call 1-877-877-7637 or TTY 1-800-735-1232

Application for the Senior Prescription Drug Assistance Program

AGENCY USE ONLY	Branch 5515	Worker ID
Case Number	Case Name	Prime #

Print. Use blue or black ink.

① Name (Last, First, M.I.) Other Names Used

Home Address - is this a change of address? ☐ Yes

Street City State Zip

Mailing Address (if different)

Street or PO Box City State Zip

② Home Phone

③ Are you an Oregon resident?

☐ Yes ☐ No

④ Sex ☐ Male ☐ Female

⑤ Resources – Do you have more than $2,000 in resources? Resources are things like cash, checking, savings accounts, stocks, and bonds. Your home and car do not count as resources. ☐ Yes ☐ No

⑥ Date of Birth

⑦ Income – What is your annual or monthly gross income (before taxes)? You must send proof of this month's income with your application. Proof can be a retirement or Social Security check, a check register, **or** a print out from the Social Security Administration.

Annual: $ _____

or Monthly: $ _____

⑧ Have you had prescription drug benefit coverage in the last six months? This does not include prescription drug discount programs. It does include programs that pay for all or part of your prescription drugs. If yes, list information about that program.

☐ No ☐ Yes – List:

Before you sign, review Section 14 on the reverse side of this application.
I swear under penalty of perjury I have given true, complete information.

Full Legal Signature of Applicant Date

DHS 7212 (02/03)

For help filling out this application, call 1-877-877-7637 or TTY 1-800-735-1232

You can choose not to give this information. It will not affect your eligibility.

⑨ Social Security Number

___-___-____

⑩ If you do not speak or read English, please tell us which language you:

Read: _____

Speak: _____

⑪ If you have a sight impairment, please choose the alternate format that will meet your needs.

- ☐ Braille
- ☐ Oral Presentation
- ☐ Large Print
- ☐ ASCII Disk
- ☐ Audio Tape
- ☐ Other

⑫ Racial/Ethnic Heritage – *Choose one*

This information helps us follow Federal Civil Rights Laws. Title VI of the Civil Rights Act of 1964 allows us to ask for this information.

- ☐ White
- ☐ Black
- ☐ Hispanic
- ☐ American Indian/Alaska Native
- ☐ Asian or Pacific Islander
- ☐ Other

⑬ Authorization to release information – We can only discuss your coverage with you or someone you name. If you want someone to get or give information about you, list them below. This authorization will be in effect until your coverage ends unless you notify us.

Name (Last, First, M.I.): _____

Relationship to you: _____

Phone Number: ___-___-____

⑭ By signing this application . . .

- I understand giving false or incomplete information may delay or stop my coverage.
- I allow the Department to use my Social Security Number for the purposes explained in the enclosed booklet.
- I have read and understand the non-discrimination statement shown on page 3 of the enclosed booklet.
- I agree to cooperate with the Department if my case gets chosen for a review.
- I will give proof of the statements I have made, and allow the Department to contact other people and agencies to get proof I do not have.
- I have read and understand my rights and responsibilities as shown on page 4 of the enclosed booklet.
- I understand that there is an annual fee of $50, and this fee is not due until I am found eligible.